Louisiana State Board of Medical Examiners

Physical Address: 630 Camp Street, New Orleans, LA 70130
Mailing Address: P.O. Box 30250, New Orleans, LA 70190-0250
Phone: (504) 568-6820, Fax: (504) 568-0503

SHORT-TERM RESIDENCY PERMIT
QUALIFICATIONS/ INSTRUCTIONS
(REV. 010505)

The board may issue a temporary permit for the purpose of serving a preceptorship or participating in a short-term residency program. The board must approve the preceptorship or residency program prior to the applicant's participation. Contact the LSBME to see if the program is approved.

Qualifications for Permit

- Must be at least 21 years of age and of good moral character
- Be a citizen of the United States or possess valid and current legal authority to reside and work in the United States duly issued by the commissioner of the Immigration and Naturalization service.
- Possess a current unrestricted license to practice medicine issued by a medical or osteopathic licensing authority of another state or satisfactory documentation of having passed the examination (FLEX, USMLE, NBME).
- Written commitment from an accredited Louisiana medical school from the physician under whom the preceptorship or short-term residency describing the capacity in which the applicant will be serving and the inclusive dates of service. This letter must be signed by the director of the program and must be mailed directly to the LSBME.
- Pay the appropriate fee of $100.00. This fee is non-refundable.
- Applicant appears in person at the LSBME and presents to a member of the board or its designee the original:
  - Doctor of Medicine /Osteopathic Degree
  - Original State Medical License (wall certificate)
  - If not licensed in any state, the original examination score report.

General Information

The state of Louisiana does criminal background checks as part of the application process through the state -Louisiana Department of Public Safety and Corrections-DOC and Federal Bureau of Investigations-FBI. Materials for this purpose can be obtained by writing to:

LSBME-Attn: CB
P O Box 30250
New Orleans, LA 70190-0250
Or
E-mail: lsbmemat@lsbme.louisiana.gov

**Applicants with criminal history may expect delays in the application process.

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MUST BE TYPED *OR* BLOCK PRINTED

ATTACH PHOTO HERE

APPLICATION FOR SHORT TERM RESIDENCY PERMIT

Name: Last		**First**		**Middle**		**Suffix (Sr., Jr.)**	**Suffix (MD/DO)**
List all names in which you have ever been known:							
Social Security Number		**Driver's License Number & State**		**One Year Residency to be served:** **From:** **To:**			
Addresses	**Residency Address**	**Name of Hospital & Department**		**City**		**State**	
		Zip + 4	**County/Parish**	**Country if not U.S.**	**Telephone (Area code, #, Ext.)**	**Pager Number**	
	Home Address	**Street & Number**		**City**		**State**	
		Zip + 4	**County/Parish**	**Country if not U.S.**	**Telephone (Area code, number).**		
	Preferred Mailing Address	**Street Number or Post Office Box**		**City**		**State**	
		Zip + 4	**County/Parish**	**Country if not U.S.**	**Telephone (Area code, #, Ext.)**	**Pager Number**	
Identification	**Race**	**Sex**	**Weight**	**Height**	**Eyes**	**Hair**	**Marks**
Birth **(must submit ORIGINAL or Certified Copy of birth certificate)**	**Place**		**Date**		**Are you a U.S. Citizen?**		
	If not native born citizen of the U.S., give the following information:	**Type of visa:**					
		If Naturalized, give certificate number:					
		INS number:					
		Petition number:					
		Date issued:					
		District court through which issued:					
Marital Status	**Spouses First Name:**	**Last Name (if different from yours)**					
U.S. Active Duty	**Branch**	**Dates Served:** **From:** **To:**				**Discharge**	

Education			Post Graduate Training		
High School			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/Year Graduated**		**Month/Year Started**	**Monty/Year Ended**	**Specialty**
College/University			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/ Year Ended**	**Degree**	**Month/Year Started**	**Monty/Year Ended**	**Specialty**
College/University			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/ Year Ended**	**Degree**	**Month/Year Started**	**Month/ Year Ended**	**Specialty**
College/University			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/ Year Ended**	**Degree**	**Month/Year Started**	**Month/ Year Ended**	**Specialty**
Professional School			**Hospital/Program**		
City, State & Country, if not U.S.			**City, State & Country, if not U.S.**		
Month/Year Started	**Month/ Year Ended**	**Degree**	**Month/Year Started**	**Month/ Year Ended**	**Specialty**

Practice History and Non-Professional Activity (Do NOT include Training)
Account for ALL time not specified above, in chronological order, from High School to the present.

From MO/YR	To MO/YR	City	State or Country	Employer or practice setting (Clinic, Hosp., Solo/Group, Etc.)	Specialty or Activity
/	/				
/	/				
/	/				
/	/				
/	/				
/	/				
/	/				
/	/				
/	/				

States in which license/certificate obtained and basis of licensure/certification

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To be completed if applying based on reciprocity

VERIFICATION / ENDORSEMENT

Section 1: To Applicant— Complete Section 1 of this form and forward it to the licensing agency of each state in which you have ever obtained licensure/certification, whether permanent or temporary. If necessary, this form may be duplicated.

I hereby authorize the licensing agency of the State of _____to release all information on file concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

_____ _____
TYPE OR PRINT YOUR FULL NAME SIGNATURE

_____ _____
LICENSE NUMBER AND DATE ISSUED ADDRESS

_____ _____
SOCIAL SECURITY NUMBER CITY, STATE, ZIP CODE

Section 2:* THE SECTION BELOW IS TO BE COMPLETED BY THE VERIFYING/ENDORSING STATE *and returned to the Louisiana State Board of Medical Examiners, P.O. Box 30250, New Orleans, LA 70190-0250. This form is NOT to be returned to the Applicant.

A. This is to certify that the records of the licensing Board of the State of _____indicate that the above-named individual was issued license/certificate No._____ dated_____ on the basis of written examination (state name of examination)_____; reciprocity with the state of _____; other basis (please name)_____.

B. *If State Board Examination,* provide statement of grades or attach hereto.

C. Provide the following:

1. Is this license/certificate current? ..... ☐ Yes ☐ No ☐ Cannot Divulge
2. Is this license/certificate in good standing? ..... ☐ Yes ☐ No ☐ Cannot Divulge
3. Has this individual ever been warned or reprimanded? ..... ☐ Yes ☐ No ☐ Cannot Divulge
4. Has this individual license/certificate ever been revoked? ..... ☐ Yes ☐ No ☐ Cannot Divulge
5. Has this individual license/certificate ever been suspended? ..... ☐ Yes ☐ No ☐ Cannot Divulge
6. Has this individual license/certificate ever been placed on probation? ..... ☐ Yes ☐ No ☐ Cannot Divulge
7. Has this individual license/certificate ever been restricted in any manner? ..... ☐ Yes ☐ No ☐ Cannot Divulge
8. Has this individual ever had any charges filed against him/her? ..... ☐ Yes ☐ No ☐ Cannot Divulge
9. Do you know of any information that may be a discredit to this person? ..... ☐ Yes ☐ No ☐ Cannot Divulge
10. Do your files indicate any derogatory information whatsoever? ..... ☐ Yes ☐ No ☐ Cannot Divulge

REMARKS_____

_____

_____ _____
Date Signature

_____
Title

BOARD SEAL

_____
Name and address of licensing agency

NOTE TO BOARD COMPLETING THIS FORM: If answer to 1 or 2 is "No", or 3 through 10 is "Yes", explain and attach certified copies of pertinent material (i.e., Notice of Hearing, Final Decision, Consent Order/Agreement, etc.).

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OATH OR AFFIRMATION

Answer the following questions
(Yes answers must be explained in sworn affidavit *-AFFIDAVIT MUST BE TYPED!*)

		YES	NO
1.	In the five years prior to this application, have you had any physical injury or disease or mental illness or impairment, which could reasonably be expected to affect your ability to practice medicine or other health profession?		
2.	In the five years prior to this application, have you been addicted to or used in excess any drug or chemical substance including alcohol or treated through a drug or alcohol rehabilit ation program?		
3.	Have you ever, either as an adult or juvenile, been cited, arrested, charged, convicted or pled nolo contendere to, violation of any: a) State statute?		
	b) Federal statute?		
4.	Has your application for examination or license ever been rejected or denied?		
5.	Have you ever failed a licensure/certification examination? If yes, how many times?_____		
6.	Have you ever been denied membership in a state, county, or local professional society?		
7.	Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?		
8.	Have you ever been denied, had suspended, revoked or restricted, or voluntarily relinquished, staff or clinical privileges in any hospital or other health care institution or organization?		
9.	Have you had any malpractice claims filed, settled or adjudicated against you within the last five (5) years?		
10.	Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?		
11.	Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?		
12.	Have you ever been the subject of any type of disciplinary action or inquiry by any licensing agency, hospital, institution, society, etc.?		
13.	Have you ever agreed not to seek re-licensure in any licensing jurisdiction?		
14.	Have you ever been, or are you currently in the process of being denied, terminated, suspended, refused, limited, placed on probation or placed under other disciplinary action with respect to your participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)?		
15.	Has any court determined you are currently in violation of a court's judgment or order for the support of dependent children?		

OATH OR AFFIRMATION OF APPLICANT

I HEREBY swear or affirm that all statements made and information provided in or with this application are true, correct and complete; that I am the person named in the credentials herewith presented and that I am the original and lawful possessor of such documents; that the photograph submitted to LSBME is a true likeness of me and that it was taken within the last 60 days; that in consideration of the issuance to me of a license/certificate to practice in Louisiana, I swear that I shall observe, abide by and uphold the laws of the State of Louisiana governing my practice and that I shall abstain from unethical, deceptive and fraudulent methods of practice and from immoral, unprofessional and unethical conduct, and that I shall not associate professionally with nor become a partner or employee of any person who resorts to such practices. I hereby agree that the violation of this oath shall constitute cause sufficient for the revocation of said license/certificate and surrender of the rights and privileges accorded me thereunder.

Signed _____
Full Name

Subscribed and sworn to before me this _____day

of_____YEAR_____

_____
NOTARY PUBLIC

My commission expires_____

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THIRD PARTY AUTHORIZATION

Insert Full Name:

I understand and acknowledge that the submission of an application to, as well as the acceptance or maintenance of, any license, permit, certificate and/or registration (hereinafter referred to as a "license") issued by the Louisiana State Board of Medical Examiners (the "Board") shall constitute and operate as a perpetual authorization by me to each educational institution at which I have matriculated, each state or federal agency to which I have applied for any license, permit, certificate and/or registration, each person, firm, corporation, clinic, office or institution by whom or with whom I have been employed in the practice of medicine or as an allied health professional, each physician or other health care practitioner whom I have consulted or seen for diagnosis or treatment and each professional organization or specialty board to which I have applied for membership, to disclose and release to the Board any and all information and documentation concerning me which the Board may deem material to the consideration of my initial application and during such period as I may hold or maintain a license. With respect to any such information or documentation, the submission of an application to or the acceptance or maintenance of a license from the Board shall equally constitute and operate as a consent by me to the disclosure and release of such information and documentation and as a waiver by me of any privilege or right of confidentiality which I would otherwise possess with respect thereto.

By submitting an application or accepting or maintaining a license issued by the Board, I shall be deemed to have given my consent to submit to physical or mental examinations if, when and in the manner so directed by the Board and to have waived all objections as to the admissibility or disclosure of findings, reports or recommendations pertaining thereto on the grounds of privileges provided by law. I acknowledge that the expense of any such examination shall be borne by me.

The submission of an application or the acceptance or maintenance of a license from the Board shall also constitute and operate as perpetual authorization and consent by me to the Board to disclose and release any information or documentation set forth in or submitted with my application, or which then or at any time thereafter may be obtained by the Board from other persons, firms, corporations, associations or governmental entities, to any person, firm, corporation, association or governmental entity having a lawful, legitimate and reasonable need therefore, including, without limitation, the medical and/or allied health professional licensing, permitting, certifying and/or registering authority of any state; the Federation of State Medical Boards of the United States; professional organizations, associations and societies; the American Medical Association and any component state, county or parish medical society, including but not limited to the Louisiana State Medical Society and component parish societies thereof; the American Osteopathic Association; the Louisiana Osteopathic Medical Association; the Federal Drug Enforcement Agency; the Louisiana Office of Narcotics and Dangerous Drugs, Office of Licensing and Registration, Department of Health and Hospitals; federal, state, county or parish and municipal health and law enforcement agencies and the Armed Services.

I understand that this authorization and consent is valid commencing on the date herein below subscribed and that such will remain in force and effect until and unless I withdraw my application for, or no longer possess or maintain, a license issued by the Board. I also acknowledge that a duplicate of this document may serve as an original.

Signature: _____
Full Name

****TO BE SIGNED IN THE PRESENCE OF A NOTARY**

Subscribed and sworn to before me this _____ day

of _____, 20 _____.

_____
Notary Public

Seal

MY COMMISSION EXPIRES: _____